SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Filing at a Glance

Company: Federal Insurance Company

Product Name: Employer Stop Loss	SERFF Tr Num: CHUB-125723299	State: Arkansas
TOI: 17.0 Other Liability - Claims Made/Occurrence	SERFF Status: Closed	State Tr Num: #371729 $20
Sub-TOI: 17.0009 Employers Liability	Co Tr Num: 08-AP-5-F	State Status: Fees verified and received
Filing Type: Form	Co Status:	Reviewer(s): Betty Montesi, Edith Roberts
	Authors: Diana Cardone, Susan Leonard	Disposition Date: 07/15/2008
	Date Submitted: 07/08/2008	Disposition Status: Approved
Effective Date Requested (New): On Approval		Effective Date (New):
Effective Date Requested (Renewal):		Effective Date (Renewal):

State Filing Description:

General Information

Project Name: Arkansas Application	Status of Filing in Domicile: Not Filed
Project Number:	Domicile Status Comments:
Reference Organization:	Reference Number:
Reference Title:	Advisory Org. Circular:
Filing Status Changed: 07/15/2008	
State Status Changed: 07/15/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE Federal Insurance Company

NAIC: 038-20281

FICA: 13-1963496

Form #'s 14-03-0485 (7/2008) Application

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

In response to Bulletin 6-2008, we are adding the required notice to our stop loss application. This form was previousl filed and approved by you department This is the only change being made to this form. Your approval will be greatly appreciated.

Your approval for policies issued under this program will be greatly appreciated.

Sincerely,
Chubb & Son
A division of Federal Insurance Company
By: Fran Muldoon
Fran Muldoon, AVPManager,
State Filings Department

Company and Contact

Filing Contact Information

Fran Muldoon, Manager - CPI State Filngs Dept.	fmuldoon@chubb.com	
202 Hall's Mill Rd.	(908) 572-2875 [Phone]	
Whitehouse Station, NJ 08889-9977	(908) 572-4034[FAX]	

Filing Company Information

Federal Insurance Company	CoCode: 20281	State of Domicile: Indiana
202 Hall's Mill Road	Group Code: 38	Company Type:
P.O. Box 1650		
Whitehouse Station, NJ 08889-1650	Group Name:	State ID Number:
(908) 572-4726 ext. [Phone]	FEIN Number: 13-1963496	

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	$20.00 Fee to correct a previously filed form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federal Insurance Company	$0.00	07/08/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
00371729	$20.00	07/08/2008

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	07/15/2008	07/15/2008

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Disposition

Disposition Date: 07/15/2008
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Stop Loss Application	Approved	Yes

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Stop Loss Application	14-03-0485	7/2008	Application/ Binder/Enrollment	Replaced Form #: 14-03-0485(Ed 3/2003) Previous Filing #: 03-AP-F		14-03-0485 EE Stop Loss App Rev 7 2008.pdf

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

EMPLOYER STOP LOSS APPLICATION

BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY (THE "COMPANY")

APPLICATION INSTRUCTIONS:

1. Whenever used in this Application, the term "**Applicant**" shall mean the insured and all subsidiaries.

2. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

I. GENERAL INFORMATION

1. Name of **Applicant**: _____

2. Address of **Applicant**: _____

   City: _____ State: _____ Zip Code: _____ Telephone: _____

3. Web address: _____

4. Name and Address of Primary Contact:

   City: _____ State: _____ Zip Code: _____ Telephone: _____

5. Other Location(s): ☐ Yes ☐ No
   If Yes, please give name and complete address of any/all including number of employees at each location.
   _____
   _____

6. Are subsidiary/affiliated/associated companies to be included under this benefit plan? ☐ Yes ☐ No
   If Yes, please state the legal name, location(s), and number of employees for each (companies under common control through stock ownership, contract or otherwise to be included): _____
   _____
   _____
   _____

II. SPECIFIC INFORMATION:

1. Enter the full name of your benefit plan(s): (A copy of such executed benefit plan(s), including all amendments, must be attached.)

   _____

2. Nature of **Applicant's** Primary Business: (SIC Code) _____

3. Federal Employer's Tax I.D.#: _____
   Number of Years in Business: _____

   ☐ Corporation ☐ Partnership ☐ Proprietorship

EMPLOYER STOP LOSS APPLICATION

4. Estimated Initial Enrollment:

_____ Single/Employee only	_____ COBRA Beneficiaries
_____ Employee and Spouse	_____ Retired Employees
_____ Employee and Child(ren)	
_____ Family (Employee/Spouse/Children)	

5. Proposed Effective Date: _____

6. Name and Address of Designated Third Party Administrator:
(Firm) _____
(S.S.N. or Tax I.D.#) _____
(Address) _____
(Contact Person & Phone Number) _____

III. POLICY PERIOD:

1. Policy Period Requested:
From _____ to _____ both days at 12:01 a.m. at the principal address of the insured.

2. Covered Persons Included:
a. Retired Employees: ☐ Yes ☐ No
b. COBRA Beneficiaries ☐ Yes ☐ No
c. Disabled Persons ☐ Yes ☐ No

3. Actively At Work Provision

☐ Actively At Work Provision Applies
☐ Actively At Work Provision Waived (with Company approval and completed employer disclosure statement)

IV. REQUESTED COVERAGE:

A. Specific Stop Loss Insurance Requested:

1. Requested Under the Policy: ☐ Yes ☐ No

2. Requested Services To Include:

Medical	☐ Yes	☐ No
Prescription Drug	☐ Yes	☐ No
Prescription Drug Card	☐ Yes	☐ No

3. Requested Services Incurred From: _____ To: _____

4. Specific Retention Amount Per Covered Person Per Policy Period: $_____

5. Insured Percentage: _____%

6. Paid by the Insured From: _____To_____

7. Claim Reporting Deadline: _____

8. Maximum Specific Benefit Per Covered Person:
   A. Per Policy Period: $_____
   B. Lifetime Maximum Per Covered Person: $_____

9. Specific Monthly Premium Rates: $_____Per Single/Employee Only Covered Unit
   $_____Per Employee and Spouse Covered Unit
   $_____Per Employee and Child(ren) Covered Unit
   $_____Per Family (Employee/Spouse/Children) Covered Unit

B. Aggregate Stop Loss Insurance Requested:

1. Requested Under the Policy: ☐ Yes ☐ No

2. Requested Services to Include:

Medical	☐ Yes	☐ No	STD/Weekly Disability Income	☐ Yes	☐ No
Dental	☐ Yes	☐ No	Prescription Drug	☐ Yes	☐ No
Vision	☐ Yes	☐ No	Prescription Drug Card	☐ Yes	☐ No

3. Requested Services Incurred From: _____To: _____

4. Run-in Limit (if applicable):
   A. Covered services Incurred from: _____ To: _____
   B. Not to exceed: $_____

5. Minimum Aggregate Retention Per Policy Period: $_____

6. Monthly Aggregate Factors: $_____Per Single/Employee Only Covered Unit
   $_____Per Employee and Spouse Covered Unit
   $_____Per Employee and Child(ren) Covered Unit
   $_____Per Family (Employee/Spouse/Children) Covered Unit

7. Insured Percentage: _____%

8. Paid by the Insured From: _____ To: _____

9. Claim Reporting Deadline: _____

10. Maximum Aggregate Benefit Per Policy Period: $_____

11. Aggregate Monthly Premium Rates:

    $_____Per Single/Employee Only Covered Unit
    $_____Per Employee and Spouse Covered Unit
    $_____Per Employee and Child(ren) Covered Unit

$_____Per Family (Employee/Spouse/Children) Covered Unit

C. Additional Options Requested:

1. Monthly Aggregate Cap Option Requested: ☐ Yes ☐ No

2. Terminal Liability Option Requested: ☐ Yes ☐ No

3. Specific Advance Option Requested: ☐ Yes ☐ No
4. $_____ Terminal Liability Risk Premium Per Employee

5. Terminal Liability Attachment Factors:
   $_____Per Single/Employee Only Covered Unit
   $_____Per Employee and Spouse Covered Unit
   $_____Per Employee and Child(ren) Covered Unit
   $_____Per Family (Employee/Spouse/Children) Covered Unit

D. Representation: Prior Knowledge of Facts/Circumstances/Situations:

No person or entity proposed for coverage is aware of any fact, circumstance, or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage, except: NONE _____ or _____
_____
_____
_____.

Without prejudice to any other rights and remedies of the Company, the **Applicant** understands and agrees that if any such fact, circumstance, or situation exists, whether or not disclosed above, any claim or action arising from such fact, circumstance, or situation is excluded from the proposed coverage if a policy is issued by the Company.

V. MATERIAL CHANGE:

If there is any material change in the answers to the questions in this Application before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

VI. NOTICES:

Receipt of any money in connection with this Application shall not constitute an acceptance of liability. In the event the Company disapproves this Application, its sole obligation shall be to refund such sum to the **Applicant**.

The Applicant's submission of this Application does not obligate the Company to issue a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** authorizes the Company to make any inquiry in connection with this Application.

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

Notice to District of Columbia,
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant

Notice to Maine, Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Florida and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony (in Oklahoma) of the third degree (in Florida).

Notice to Kentucky Applicants: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania and New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (in New York) or criminal and civil penalties (in Pennsylvania).

Notice to Washington Applicants:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

VII. DECLARATION AND SIGNATURE:

For the purposes of this Application, the undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and any attachments or information submitted with this Application, are true and complete. The undersigned agree that this Application and its attachments shall be the basis of a contract should a policy providing the requested coverage be issued and shall be deemed to be attached to and shall form a part of any such policy. The Company will have relied upon this Application, its attachments, and such other information submitted therewith in issuing the proposed coverage.

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

EMPLOYER STOP LOSS APPLICATION

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a claim or potential claim.

This Application must be signed by the chief executive officer and chief financial officer of the Insured acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature	Title
_____	_____	Chief Executive Officer
_____	_____	Chief Financial Officer

REQUIRED ARKANSAS NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

PRODUCED BY *(Insurance Agent)*	**INSURANCE AGENCY**
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	**AGENT LICENSE NO.**
ADDRESS *(No., Street, City, State, and ZIP Code)*	
EMAIL ADDRESS	

SUBMITTED BY *(Insurance Agency)*	**INSURANCE AGENCY TAXPAER ID OR SOCIAL SECURITY NO.**	**AGENT LICENSE NO.**
ADDRESS *(No., Street, City, State, and ZIP Code)*		

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CHUB-125723299*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#371729 $20*
Company Tracking Number:	*08-AP-5-F*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0009 Employers Liability*
Product Name:	*Employer Stop Loss*		
Project Name/Number:	*Arkansas Application /*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Uniform Transmittal Document-Property & Casualty	Approved	07/15/2008

Comments:

Please see attached

Attachment:

ARK NAIC trans 08 AP 05.pdf

Effective March 1, 2007

Property & Casualty Transmittal Document

Reset Form

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

3.	Group Name	Group NAIC #
	Chubb Group of Insurance Companies	038

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Federal Insurance Company	INDIANA	20281	13-1963496	

5.	Company Tracking Number	08-AP-5 F

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Fran Muldoon 202 Hall's Mill Rd Whitehouse Station NJ 08889	Manager	9085722875	908 5724034	fmuldoon@chubb.com

7.	Signature of authorized filer	Fran Muldoon
8.	Please print name of authorized filer	Fran Muldoon

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	17.0 Other Liability-Occ/Claims Made
10.	**Sub-Type of Insurance (Sub-TOI)**	17.0009 Employers Liability
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**	
12.	**Company Program Title** (Marketing title)	Employer Stop Loss
13.	**Filing Type**	☐ Rate/Loss Cost ☐ Rules ☐ Rates/Rules ☑ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	**Effective Date(s) Requested**	New: Renewal:
15.	**Reference Filing?**	☐ Yes ☑ No
16.	**Reference Organization** (if applicable)	
17.	**Reference Organization # & Title**	
18.	**Company's Date of Filing**	
19.	**Status of filing in domicile**	☑ Not Filed ☐ Pending ☐ Authorized ☐ Disapproved

Property & Casualty Transmittal Document—

20.	This filing transmittal is part of Company Tracking #	08-Ap-5 F

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

This filing is to comply with the department bulletin regarding a notice to employers purchasing stop loss insurance.
We have placed the required notice on the application. It is the only change we are making to the form.

View Complete Filing Description

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: 00.311.229
Amount: $20.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

***Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

Effective March 1, 2007

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)

(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	08-AP-5 F
2.	**This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable)	NA

3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	ESL application	14-03-0485 (Ed 7/2008)	☐ New ☑ Replacement ☐ Withdrawn	14-03-0485 (Ed 3/2003)	
02			☐ New ☐ Replacement ☐ Withdrawn		
03			☐ New ☐ Replacement ☐ Withdrawn		
04			☐ New ☐ Replacement ☐ Withdrawn		
05			☐ New ☐ Replacement ☐ Withdrawn		
06			☐ New ☐ Replacement ☐ Withdrawn		
07			☐ New ☐ Replacement ☐ Withdrawn		
08			☐ New ☐ Replacement ☐ Withdrawn		
09			☐ New ☐ Replacement ☐ Withdrawn		
10			☐ New ☐ Replacement ☐ Withdrawn		

PC FFS-1